

III. Suppurating Bubonocele. By THOMAS BRYANT (London). The patient was admitted into Guy's Hospital under Mr. Bryant. His age was 21 years. Ten days previous he noticed a small swelling in left groin, not painful until six days before, when he had a dull, aching sort of pain there. Bowels confined. Took two pills on two occasions which relieved his bowels four times in the ten days. Taxis had been freely applied. There was a small hard swelling in left groin, irreducible; no impulse on coughing. It was not very painful. He felt sick but had not vomited. Bowels not opened for three days. Swelling dull on percussion. It was regarded as an irreducible omental hernia, and next day Mr. Bryant operated, under an anaesthetic. An incision three inches long was made over the swelling in the direction of Poupart's ligament. When the skin and tissues were cut through pus escaped, and a piece of suppurating omentum was seen. An aneurism needle was passed through the upper parts of the omentum and it was ligatured with catgut and cut off. Wound was then plugged with iodoform gauze and left to granulate up. Patient made an uninterrupted recovery.—*Lancet*, Oct. 27.

IV. Hernia into the Foramen of Winslow. By FREDERICK TREVES, F.R.C.S. (London.) Patient, æt. 26 years, well developed, muscular and robust; never been ill, was steady, knew nothing of dyspepsia. On April 9, ate a hearty dinner at 3 P.M., finishing up with a considerable number of periwinkles. At 5 P.M. was suddenly seized with violent abdominal pain, situated in the umbilical region; could not recline, was bent double, became faint, broke out into cold perspiration; pain at first intermittent; abdomen not tender; vomited on 10th; nothing passed per anum. Opium was administered and bowels relieved by enema. Abdomen became swollen, especially marked in epigastrium. Admitted into the London Hospital on 11th. Great prostration, pinched face and sunken eyes of acute abdominal trouble. Tongue brown and dry, temperature subnormal, pulse soft, small and feeble. Lying upon back with knees drawn up. A little brownish fluid with faint intestinal odor vomited every half hour. Much pain about umbilicus; abdomen moderately distended; conspicuous bulging of an-

terior wall in the epigastric and hypochondriac regions; summit of swelling in median line; tenderness in epigastrium; rectal examination revealed nothing. On the 17th the abdomen was opened in median line below umbilicus. Cæcum was first sought, but neither it nor ascending colon could be felt. Left colon and sigmoid flexure were then found to be empty. It was then discovered that there was no true mesentery to small intestine. A coil of bowel was followed till a constricting ring in the epigastrium was reached, through which the bowel passed. This ring was above the position of the duodeno-jeponal fossa and had no direct relation to vertebral column. It was now surmised that it was the foramen of Winslow. In the tissues in front of the ring an artery, clearly the hepatic, could be felt pulsating. Three feet of small intestine were reduced, but it was found impossible to reduce further a distinct coil of intestine. It was also impossible to enlarge the opening. The patient never rallied. Necropsy: Commencing general peritonitis. When the abdominal cavity was fully exposed a coil of large intestine, so enormously distended as to be four inches in diameter, was found lying in the left hypochondriac region immediately under the costal cartilages of the left side. Below it the stomach, slightly distended and somewhat displaced forward and to the left, presented itself. No other viscera were to be seen except the liver and coils of the small intestine. Further examination showed that the cæcum had passed through the foramen of Winslow, and had become strangulated by the margin of that aperture. The colon, on entering the snare, had passed from right to left; the cæcum was to the extreme left of the abdominal cavity, and had forced its way through the anterior layer of the gastro-hepatic omentum, so that the vermiform appendix was actually lying on the anterior aspect of the lesser curvature of the stomach, close to the œsophagus. The diameter of the strangulated colon measured nearly five inches. This part of the bowel was nearly five inches. Both patches were limited to the ascending colon, while the other was twice as large. The intestine had given way a little in the latter situation, and faecal matter had found its way into the lesser cavity of the peritoneum. The colon outside or beyond the foramen of Winslow turned very abruptly to the left, and was then repre-

sented by the distended segment of large intestine lying above the stomach. On reaching the splenic flexure, the bowel was so sharply bent upon itself as to be again occluded. Whole spinal intestine was distended. Some four or five inches of the terminal parts of the ileum were still found within the hernial cavity. It had passed in with the cæcum, but was only partially strangulated. At the seat of stricture the colon was in front of the small intestine. Of the strangulated colon the cæcum was the part that had suffered least. There was a descending meso-colon of moderate length. The colon may be described as being very sharply bent upon itself at the foramen of Winslow. The situation of this acute bending, the seat of the stricture, would correspond to about the centre of the transverse colon. The bowel from this point to the tip of the cæcum was involved in the strangulation. The remaining half of the transverse colon was dilated by reason of the abrupt manner in which the bowel was again bent upon itself at the splenic flexure. There was no trace of an hepatic flexure. It was evident that the cœcum was undescended, and had led the way through the foramen, which admitted four fingers. It was found quite impossible to reduce the strangulated hernia. Reduction could not be effected until the hepatic artery and portal vein and bile duct had been divided. Mr. Treves expresses a belief that this form of hernia can only take place when an abnormality exists in the intestines and mesentery. Mr. Treves was only able to find four recorded instances of this form of hernia, viz., Rokitansky, Blandin, Majoli and Eliot. In the fully reported cases stress is laid on the epigastric pain, upon the presence of a swelling in that region, and upon the existence of dulness over the swollen district. In no instance was there jaundice.—*Lancet*, Oct. 13.

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EXTREMITIES.

I. **Conservative Treatment of Gunshot Wound of the Humerus.** By DR. PAVEL A. GEIER (Kaluga, Russia). A well-made and nourished young soldier was shot with a rifle discharged at a short distance from him. On examination one-half hour later, there was found a circular wound of the size of a shillingpiece, with de-